THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-3779.M4

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address RS Medical P O Box 872650 Vancouver, Washington 98687-2650	MDR Tracking No.: M4-04-4058-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address State Office of Risk Management Box 45	Date of Injury: Employer's Name: Insurance Carrier's No.: WC2002384

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/27/03	04/26/03	E1399	$100.00	$100.00
04/27/03	05/26/03	E1399	$100.00	$100.00
06/02/03	06/02/03	E1399	$1,595.00	$1,595.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in their position statement, "We have provided product information and pricing documentation along with the prescription from the patient's doctor of record. We are also including copies of EOBs from carriers who are paying at our price list."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response states, "The requestor has failed to meet its burden of proof to show that the fee for medical services is fair and reasonable, nor evidence of effective medical cost control in accordance with the Act and Rules." Carrier's EOBs denied services as, "Reduced to fair and reasonable. No schedule allowance in the Medical Fee Guidelines; fair and reasonable rate has been recommended."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

HCPCS code E1399 item should be billed at the usual and customary rate of the DME provider. Carrier shall reimburse at a fair and reasonable rate per the MFG DME IX (C).

Per Commission Rule 133.307(j)(f), the reimbursement for these items would be at a "fair and reasonable" rate.

The requestor submitted product information and redacted EOBs from other carriers indicating a fair and reasonable reimbursement that indicates that their charges were fair and reasonable per rule 133.307(g)(3)(D).

Therefore, based on this information additional reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $1,795.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of the Order.

Ordered by:

Authorized Signature	Michael Bucklin Typed Name	12/27/04 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____